IMPLICATIONS OF THE NEW SOCIAL INSURANCE MECHANISMS FOR OTHER POPULATION GROUPS*

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SOME PRELIMINARY OBSERVATIONS

As one attempts to think through and tries to spell out the implications of the new social insurance mechanisms of Medicare, he is apt to recognize two important elements in the situation that are bound to condition his outlook.

The first is the inevitable impact upon future developments in this area of some of the other important health care legislation recently enacted. To be intelligent and realistic about the induced effects of the social insurance legislation for population groups to which it does not now apply, one simply has to assess if and how these other groups or, conceivably, the population at large may be affected by those laws that do apply to them—or will in the foreseeable future.

Thus one is led to realize, second, that the task in hand, being in the nature of a projection into the future of not just one new branch of social insurance but, in effect, several new social security and public health programs, all of them still aborning, necessarily involves the compounding of judgment and conjecture. Under the circumstances, I decided the best I could do was to draw on experience we have amassed in this country in the process of developing social insurance and related programs over the past 30 years and on selected developments abroad with which I am familiar and that strike me as relevant.

In pursuing this approach, obviously, it would not be appropriate for me to pass judgment on what *should* be our future course. Rather, I consider that whatever contribution I might be able to make to this symposium consists, first, in pinning down those developments that

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are more or less clearly foreseeable because they flow from the basic rationale of the legislative program under review and follow its logic. Beyond that, I might attempt to cull out some of the factors operative in the long run that are likely to influence developments in the more distant future insofar as they fall within my frame of reference.

It is well to begin by taking stock of the problem in the solution of which the new program of Health Insurance for the Aged (the new Title 18 of the Social Security Act), as well as other recent enactments, notably the companion program of Medical Assistance (the new Title 19 of the Social Security Act), are to be instrumental and by ascertaining whether and to what extent there exists an area of agreement on the goals to be achieved and on the means to be used toward their achievement.

Social Policy Objectives in Health Care: Agreement cum Difference

Earlier this year, the National Commission on Technology, Automation and Economic Progress—a statutory and rather high-powered study group composed of scholars, civic leaders, and prominent representatives of industry and labor—submitted to President Lyndon B. Johnson and to the Congress a report that contains, among other things, an assessment of the nation's "unmet human and community needs."[1]

High up on the list of "public needs which have not been adequately met" the Commission put the nation's health needs, singling them out as one of the two "most important" problem areas (the other being the urban environment) "where new technologies can make a substantial contribution."[2]

Acknowledging that great strides had been taken in recent years toward improving the health of the population, the Commission held, nevertheless, that the medical system of the United States was facing "critical problems." It sized up the current situation in these words:

> As a nation, we have been devoting a rising percentage of our GNP [gross national product] to medical care, but the population per physician has remained essentially constant (790 to 780 per physician between 1950 and 1961). Medicare and other legislation will increase the demand for hospital services. There are still vast needs of other groups to be met. Many studies have

> shown that the socially deprived have poorer health than the rest of society: infant and maternal mortality are greater, life expectancy is less than the norm. The poor, the crowded, and ethnic and racial minorities tend to have the most illness. It is difficult to sort out the many reasons: lack of education, lack of opportunity, lack of access to medical care, inadequate housing and food—all these contribute to an environment conducive to disease, as well as to low income. One of our great lags is in maintaining the health of the people of working age as compared with other countries. The mortality rates for males in the working years in the United States is higher than those in Western Europe. . . .

As the very first among the tasks that lie ahead, over and above the implementation of the programs recently passed (including, of course, the Medicare program), the Commission named the need for "a broader effort to achieve . . . fuller access to diagnostic and patient care facilities by all groups in the population".[3]

Now, "access to diagnostic and patient care facilities" is precisely what the Medicare legislation of 1965 is all about—as far as persons aged 65 and over are concerned. Translated into concrete terms, then, the foregoing is, in essence, a plea for greater accessibility for "all groups in the population" to such facilities, although not necessarily all of those and, on the other hand, not necessarily only those, nor of necessity on the same terms or by the same means as under the programs for persons aged 65 or older.

Stated in such broad terms, and with the all-important "open ends" that it contains, this formulation of objectives is hardly controversial. Important differences in the outlook upon future developments that do exist, including even the opposite poles of the range of contrasting views prevalent today, revolve around the "how" and "when" of achieving the essentially agreed-to goals.

To some extent, the agreement on *ultimate* objectives between persons or groups subscribing to different views on how to get there encompasses an area of agreement, nevertheless, as regards certain foreseeable developments in the *not so distant* future. To be sure, their respective evaluation of the state of affairs that they foresee as likely to be brought about may widely differ, just the same. A telling example of this agreement *cum* difference is to be found in the pronouncements made not long ago by spokesmen for the American Medical

Association and of the Blue Cross Association respectively. (The Blue Cross Association will be the largest single administrator of Medicare for the federal government.) As reported in the press, Dr. James Z. Appel, president of the A.M.A., and Walter J. McNerny, president of Blue Cross, agreed that there will be extensions of the program as initially enacted, both in respect of the categories of persons covered and the scope of protection offered them under the insurance programs.[4] To Dr. Appel this development represents "socialized medicine"; to Mr. McNerny it does not.

In the present context, certainly, the agreement on probable developments would appear to be the more significant element in these pronouncements. For—given the emotion-laden quality of the designation "socialized"—it may not be far-fetched to conjecture that, if future extensions of Medicare should prove less distasteful than anticipated by the one speaker or more bothersome than envisioned by the other, the readiness or hesitancy of either spokesman to tag the program with a "socialist" label might undergo a change. At the same time, one must not belittle the importance of the presence or absence of strong negative feelings among members of any important party at interest whose cooperation with the program is an essential condition of its success. On the one hand, and in the best sense, such strong feelings can spur constructive efforts toward finding alternative solutions to pressing problems; on the other hand, and in their least helpful aspects, they may cause problems to remain unresolved longer than necessary.

Growth of a Program is not an Automatic Process

The statements referred to above suggest that the first thought that comes to many minds as we consider the impact of the Medicare program and attempt to project its future is an expectation that it will grow. In part at least, this expectation reflects a view that is rather widely held, to the effect that government programs, especially social programs making available new benefits, are bound to expand once they have been launched. Yet, in this general and unqualified sense in which they are often expressed such statements are of doubtful validity. (Many an expert in social programming with some experience in establishing and nurturing new social programs in underdeveloped nations has had to discover this for himself.) It is important to make

explicit the presumptions that underlie the exception or prediction of growth, for only if the unspoken premises are fulfilled will it come true. These premises are: 1) that the program can be made to work; 2) that it is found to give to those whom it is intended to benefit something they consider worth having; 3) that it arouses a demand for more of the same or of additional benefits on the part of those covered, and for similar benefits on the part of those not covered by the program; and 4) that government is alert to, and responsive to, the needs and desires of substantial sectors of the population.

The fact that, in the United States, expectation of the almost certain growth of any and all new governmental benefit programs is so general bespeaks a tendency to take for granted that the government will make a go of any such program, i.e., that the program will be made to work and will work well. This is no mean compliment that we are paying to our otherwise much maligned public administrators. (In a majority of countries, today, the difficulties in the way of establishing conditions for the proper and efficient administration of new programs present a very real hurdle to the implementation of forward-looking social policies.)

Similarly, we appear to take for granted that the average United States citizen knows a good thing when he sees it, that by common effort groups of citizens can generate demands for legislation and are, by and large, effective in getting their elected officials to pay attention. This, in turn, is an expression of our trust in the democratic nature of our political process. (The absence of like circumstances, especially the last of these several conditions, in some other countries has caused any number of social programs to retain over prolonged periods of time the narrow and restrictive features characteristic of, and appropriate to, a pilot project or a beginning venture. In not a few countries, the unhappy result has been that legislation intended for ever broader application has become a preserve for a privileged few.)

Let us note, then, that the growth and development of social programs, far from being "automatic" phenomena depend, in the first place, on the program in question and on the way it is implemented, and that, in the second place, they presuppose certain fostering conditions that are rooted both in the state of the arts and the state of people's minds. (Again, the object-lesson is well illustrated by the experience gathered in a number of countries with ambitious and compre-

hensive programs on their statute books that have remained dead letters, largely because neither material nor human resources have been available or have been developed to lend substance to the promise.)

The sheer administrative job of planning, launching, coordinating and supervising the program is in itself a tremendous managerial task. Moreover, a crucial factor, and a point of continuing sensitivity, in the development of Medicare over the years to come will be the working-out in practice of the tricornered relationship between the insured, the insurer (i.e., the government and its nongovernmental carrier agents), and the medical and allied purveyors (including, of course, the hospitals) in a smooth, efficient, economical and mutually satisfactory way. Recent instances of doctors' strikes and of less drastic yet sufficiently pronounced expressions of disgruntlement among doctors involved in the operation of long-established national health care programs in other parts of the world are vivid reminders to that effect.

Built-in Growth Factors

Fortunately, we are a dynamic nation, skillful and inventive in the art and technique of large-scale administration, and ever ready to put new technologies into its service. The successive modernizations of record-keeping and claims-processing operations in our social security program, as it has evolved to-date, bespeak these qualities and their undeniable success. Fortunately also, we are imbued, as a society, with a deeply rooted desire for improvement and perfection, and possessed of a large measure of good will in seeking to realize them, and—last, but not least important—we are dedicated to respecting, and conforming to, the law of the land. An important precedent has been set at an earlier point in the development of our social security program in which all these qualities were brought to bear, and the ensuing outcome has been signally successful. I am referring to the initiation, in 1956, of the disability insurance program which, like Medicare, involves the cooperation of government, the medical profession, and other nongovernmental interests (albeit in different roles and in a different "mix") and which, like Medicare, had been a heatedly contested issue prior to enactment.

Thus, we are launching our limited health insurance program—the most recent extension of the protective umbrella of our social security fabric and one that, in importance, certainly equals the intro-

duction of disability insurance in 1956 and, before that, survivors' insurance in 1939—under favorable auspices. Justifiably, therefore, we may be hopeful that the program will get off the ground reasonably successfully.

As with all new programs, initial success necessarily entails, however, a confrontation with workloads and problems that defy accurate prediction and estimation in advance. The reason for this phenomenon is the removal of or, at any rate, the loosening of restrictions upon the effective demand for services that, even though they may have long been needed, were not sought before in view of the costs involved. The effect of this removal or loosening of restrictions upon demand for services will be compounded by the discovery, through the operation of the program, of existing needs (e.g., ailments) previously unknown to those affected.

This case-finding function of new social programs—even though, in a sense, incidental—is socially, and in the present case especially from the vantage point of public health, one of their most significant results. Even though realistic launching plans must and do make allowance for an initial backlog accumulation of demand (which is all the greater, the better the program is publicized in advance), the exact magnitude of this factor is impossible to gauge—especially in the second of its two aspects referred to above.

This phenomenon of built-in growth "from within," so to speak, is the first to be taken into account. Another built-in expansion factor also affecting *directly* only those covered by the legislation already enacted will be the pressure generated to widen the initial scope of benefits at the points where present limitations are felt most. Thus, there are virtually certain to arise pressures for the liberalization of the program of Health Insurance for the Aged (for the benefit of those already covered thereunder) in respect of: 1) present restrictions of, and limitations on, curative care and implements, and 2) the exclusion of preventive care. Pressure of the first type is most likely, of course, to come from the insured themselves. To what extent it may materialize, and how strong it might be, will largely depend on how speedily and effectively supplementary private arrangements will be offered to close the existing gaps in protection. (Judging from evidence to date, considerable activity is being devoted to this opportunity by the various private carriers—how much progress toward truly more adequate protection will be made re-

mains to be seen.)

Pressure of the second type is more likely to come in the first place from government and from the carriers; and, only secondarily, i.e., if remedial action is too long delayed, from the insured; and, ultimately, from the general public. This is safe to predict, both on the strength of health insurance experience in other countries and on common-sense grounds: to treat is generally costlier than to prevent (even if the liability for treatment is limited); consequently, provisions for the early detection for illness, notably through routine examinations, are money savers. Domestic experience, likewise, confirms this. Just recently, James Brindle, president of the Health Insurance Plan of Greater New York, appearing on behalf of Group Health Association of America (GHAA) as a witness before a congressional committee, stated that the members of GHAA-affiliated cooperative health-care prepayment plans, largely because of the "heavy emphasis on preventive medicine" in these plans "spent, on the average, 40 per cent less time in our nation's crowded hospitals in 1962 and 1963 than did patients covered by Blue Cross-Blue Shield or indemnity plans."[5]

It might be asked how any such amendments of the law, or extension or supplementation of benefits now provided in the law for the benefit of those insured would affect "other population groups." The answer is that each of the factors involved in rendering the services in question is already in short supply. Therefore, to the extent that more of them are made available to the insured on a preferred basis (whether by government or through supplementary private arrangements matters little), their supply will become tighter at least in some measure and for awhile—for the noncovered groups.

In this connection, and for similar reasons, I should mention here—without discussing it in any detail—the companion program of Health Insurance for the Aged, to wit: Grants to States for Medical Assistance Programs (Title 19 of the Social Security Act). This program represents a special case of "growth from within," as far as that program is concerned, but with reverberations outside it. Based on present federal law, rather than in anticipation of any future amendments thereof, it is a virtual certainty that over the next several years a growing number of aged persons and other persons of modest means will be entitled to benefit, and will be served, under state plans established pursuant to, and in conformity with, this new legislation.

A rather exacting timetable is attached to this legislation, which will bring into operation by July, 1967, only a little over a year away, a minimum of five important services in all states choosing to cooperate under it, namely, inpatient and outpatient care in hospitals, physicians' care, x-ray and laboratory services and nursing home care. While it is optional with each state whether it wants to cooperate or not, any state that, by 1970, does not choose to do so—and that is little over 3 years away—hereby forfeits all federal grants for medical assistance under the various categorical public assistance programs. Thus the incentive for the states' participation is great.

If they cooperate and make available the five required types of services by 1967, it is expected of them that barely 8 years later, by 1975, they will give complete care to the medically indigent, i.e., not only to people already on public assistance programs, but—to borrow an apt formulation that *The New York Times* used recently—anybody who would be pauperized by illness if this help were not available.

Thus, by 1975, according to the text of the law,[6] "comprehensive care and services . . . including services to enable such individuals to attain or retain independence or self care" should be available by July 1975, to "substantially all individuals who meet the plan's eligibility standards with respect to income and resources. . . .*

From the foregoing it is apparent that some growth and expansion in both the Health Insurance and the Medical Assistance programs is bound to occur in the next several years, even in the absence of any extension of Federal legislation pertaining to either program. As a consequence, there is likely to occur, for some time, a continuing shift in the utilization of scarce facilities and services in favor of those insured for medical and hospital care (Title 18) and of those who receive such care on an assistance basis (Title 19). As was pointed out, this will cause some strains and stresses, at least temporarily and in some locations, on their availability to noncovered groups.

Probable Coverage Extensions to Those "Next in Line"

To say that the recent legislation will entail some shift in the utilization of present hospital, medical, and related resources from

*One highly competent observer, Professor Herman M. Somers of Princeton University, Princeton, N. J., has estimated that the number of persons eligible for service under the expanded Kerr-Mills provisions of Title 19 may attain by 1975 a total of 35 million—more than twice the number of those now eligible under the insurance provisions of Title 18.[7] Others think their number by then might reach nearer 40 million. Of course, these estimates pertain to the largest possible number that can eventuate only if all states choose to implement this program, and do so to the fullest extent possible.

groups not covered to those covered by such legislation is not to say that the noncovered groups will be the losers or will derive no benefit from the legislation as it stands. Thanks to Health Insurance for the Aged, millions of active members of the labor force will be relieved of a heavy burden, both financial and other, as and when their aged parents and other dependents gain the very substantial entitlement provided thereunder to insured hospitalization and medical-surgical care, as well as aftercare, both institutional and at home.

It is this very fact that will set in motion a process of coverage extensions of the Medicare program. Obviously, if the burden of coping with the cost of major illness weighs heavily on the shoulders of a family provider even during his most active middle years, a similar burden will be proportionally all the greater if it must be borne by a retired man, aged 65 or older, as the husband of an ailing wife below age 65, and therefore not yet eligible for health insurance benefits, or of an ailing dependent child. The number of spouses below age 65 of persons 65 or older is estimated at about 2.5 million. Dependent children of such workers are estimated to number about 400,000.

It would be hard to resist the conclusion that the precedent set under OASDI in connection with other insured risks will be followed, with certain necessary modifications. It will be recalled that neither the old-age nor the disability provisions of the Social Security Act contained, in their original form, benefits for the dependents of the insured worker. In both instances, the inescapable logic of the presumptive need of the dependent wife and children of these beneficiaries led to the addition of dependents' benefits within a few years from the date of the first enactment. An analogous extension of benefits to the dependents of persons entitled to Medicare, regardless of their age, will recommend itself equally cogently and may materialize in comparably short order.

Extension of coverage under the Medicare program to other categories of social security beneficiaries than the aged, likewise, must be considered a virtual certainty for reasons that are no less compelling than dependents' needs. Premature aging and forced retirement from the labor force are causing an ever larger number of persons below the normal retirement age to claim social security benefits, despite the fact that their benefits are actuarially reduced for each month by which the claimant's age falls short of the normal retirement age. These early re-

tirees between ages 62 and 65, numbering at present 3.4 million, have on average lower social security benefits than those retiring at higher ages; many are believed to be in poor health—this being probably the most frequent reason why they retired early—and they are, therefore, if anything more rather than less, in need of the benefits of health insurance. What has been said of the presumptive need for these benefits as regards dependents of those retired at age 65 or over is even more applicable as regards dependents of the prematurely retired, many themselves ailing. These dependents may number a few hundred thousand.

The case for Medicare coverage extension to those recipients of social security benefits who were forced to retire from the labor market at an even earlier age than 62, due to a disability of long and indefinite duration that has disqualified them from any and all substantial gainful employment, was made, even before the present legislation was passed, in the latest Report of the Social Security Advisory Council.[8] This group, now nearing one million, includes a considerable number of children disabled before their 18th birthday.

This leaves to be considered only one major group of OASDI beneficiaries—some with, others without, health insurance rights under present legislation—to wit: the survivors of deceased workers. Widows and widowers at or above age 65 are in, those aged from 60 (62 for widowers) to 64, and those of younger age but entitled to cash benefits because they have in their care dependent children of the deceased are out. Likewise unprotected under the health insurance provisions are the double orphans. One would belabor the obvious were he to prove that presumptive need for protection of an equilibrium—precarious at best—in family finances from the unforseeable drains due to ill-health are just as great in each of these categories—estimated to aggregate up to 4 million persons—as among those aged 65 and over, and in not a few instances probably greater.

Under the Kerr-Mills Act, many persons in these several categories now obtain the necessary care if they are on public assistance or are found to be medically indigent, provided they live in a state that has made provision for the implementation of this law. As a result of the new Title 19 of the Social Security Act, all medically indigent, in whatever state they may find themselves, might have available to them the full spectrum of medical and related services in 1975, if not sooner, only provided all states choose to implement this new federal enactment.

Without belittling the importance or the value of this ultimate safeguard, resort to it will be tied, in future as at present—unless the character of this program brings about a dramatic change—to an individual test of income and means. This will place applicants in a position similar to that from which social security recipients aged 65 and over (and by then probably other categories of beneficiaries) will have been redeemed by the Medicare legislation. Without any readily apparent justification for such differential treatment, the case for their inclusion under Medicare will be hard to gainsay.

The End of the "Blanketing-in" Phase and the Eventual Need for a New Look

To those who regard a new social program with distrust, not to say misgivings, as a mere "foot-in-the-door," a stepping stone to an even bigger and more inclusive one, the foregoing enumeration of plausible, logical and therefore probable extensions of Medicare in the next several years may read like a litany of doom. It may seem to them—as one able critic (himself a former social security official) put it many years ago—as though there could be no end to such expansion because "once a new principle is established, the whole chain reaction of liberalization [to correct what seem to be glaring anomalies] . . . is virtually inevitable."[9]

There is some truth to this observation, but there are also distinct limits to its applicability. The truth is rooted in the twin facts of life that unmet needs or problem areas of a kind similar to those already met will press for a solution, and that lesser needs come to the fore and take on greater urgency as the most pressing (or, at any rate, the most pressure-generating) needs are met. The limits to this process of extension, on the other hand, present themselves in the form of institutional obstacles, notably the conflict between the new program and some already existing programs, administrative and financial hurdles, and yet other incompatibilities.

To illustrate, in the case of Medicare, one needs to think merely of the complications which would arise if extension of this program were proposed to cover two other plausible categories of potential recipients: 1) workers who have sustained a disabling work accident or a disabling occupational illness, and 2) unemployed workers. Unfortunately, many employment injury victims and virtually all the unemployed now lack such protection. That they need it few will doubt.

Yet, the fact that a separate and altogether different system, namely workmen's compensation, now has and jealously asserts jurisdiction in the area of work injury protection (even though this protection is far from uniform or complete) would unquestionably interpose very serious problems, not only of a political nature but of practical feasibility, short of a major revamping of the present approach. In the case of the unemployed, similar jurisdictional problems constitute a lesser obstacle; here the incongruity of assuring unemployed workers a type of protection which, though equally needed at all times, is generally denied to employed workers (unless they enjoy such protection as a fringe benefit of their employment) may prove to be the greater hurdle.

It is at such points as these that the "blanketing-in" technique is likely to give way to a broader reconsideration of issues and needs, i.e., a full-scale review of all available solutions and their merits—at least if what *The New York Times* recently called "patchwork additions" are to be avoided.[10]

Thus, we can forsee that the time will come when the great debate on the proper directions in public policy on health care is likely to be resumed in its fullness, with a considerable potential for renewed conflict between the parties at interest. Whether this big issue will be left to be tackled in earnest only until after the "problem groups" have been substantially taken care of and, by and large, the only remaining "disadvantaged" persons (in terms of health protection) will be active members of the labor force and some of their dependents, or whether it will move into focus before that point is reached, is hard to predict. What can be predicted with reasonable certainty is that the confrontation with this issue is bound to arise and that the above-named juncture is the very latest point in time at which it will have to be faced. The reason: a growing financial burden in connection with the gradual expansion of coverage and of services that must be borne by the economically active population either in the form of contributions and payroll taxes or, following the precedent set in the Medicare legislation itself, from general tax revenues or—most likely—a combination of both.

The Next Big Issue: A Public Policy for the Health Care of the Nation

The costs of medical, hospital, and allied care will rise not only because of the foreseeable increase in the effective demand for services,

but also because of stepped-up capital expenditures on facilities and other necessary expenditures, notably in connection with training of professional and subprofessional personnel in order to assure that the services sought can in fact be supplied. More of this later.

Aside from higher costs, a number of other changes are likely to have taken place by the time the issue is joined. These are bound to affect the frame of reference in which it will be discussed, the alternatives that will be considered, and the ultimate choice made. Several important developments will figure prominently in this setting: 1) the spread and position of employment-connected health-benefit plans and of other group and individual health insurances; 2) the kinds, the level, and the volume of services available at that time under the government programs and under the other plans; 3) concomitantly, the general expectations then prevailing as to the needed types and scope of protection; 4) the concrete possibilities of so organizing medical and allied care as to fill the bill.

As regards the first set of these circumstances, it stands to reason that employer-sponsored health-benefit programs, as well as other nongovernmental health insurance arrangements, will have experienced a spurt—what with the shift to government of the bulk of the costly responsibility for the aged and retired workers, and given the greater insurance consciousness that will have been engendered in the wake of Medicare and by the recurrent publicity attendant to its voluntary insurance operations. To what extent these media will have succeeded in bringing protection to the less organized and (at present) less well-provided-for categories of employees, e.g., those in small firms, in nonurban areas, in agricultural and certain other lines of work, and to those small-scale self-employed persons whose economic position most resembles theirs, is still an open question that only the future can answer. Clearly, the more selective the coverage under these plans proves to be, the more will be left to be done by government or at government initiative.

But the possibility is very real that the better protection under collectively bargained plans may considerably dampen interest in general legislation among the core of organized workers. (Some precedents to this effect exist today in the area of work-injury protection, which is so badly in need of improvement.)

As regards the second and third sets of circumstances that will shape

the framework within which the policy issue will be viewed (the type, quality, and quantity of services available, and the common expectations with regard to these) we are safe to assume that both standards and aspirations will be high. Already, bills are pending in the Congress that aim at making available under the compulsory part of the Medicare program those very services that were excised from the list in the legislative process. Simultaneously, insurance carriers are vying with each other in offering supplementary protection to reduce the deductible and coinsurance features and to provide extensions of benefit rights. As stated above, it appears but realistic to expect that within several years the health insurance cover under Medicare (inclusive of auxiliary provisions of various kinds) will be solid and substantial, both in breadth and in depth.

An additional, and highly significant, factor that will reinforce this tendency toward inclusiveness and comprehensiveness of the insurance cover is to be found in the provisions of Title 19 already cited. The provisions of this title promise to take on more and more—and by 1975, presumably, completely—the character of a general comprehensive health service available throughout the country to the low-income strata of the population. It stands to reason that the beneficiaries of prepaid medical care will not settle for less than the full range of services made available "free" to those aided under Medical Assistance, and that the aspirations of the economically active population could hardly fall below those of either group.

Most difficult to visualize among the four sets of circumstances specified above as likely to constitute the framework for the public decision to be faced, is the kind of organization and assured supply of medical resources necessary for the gamut of varied high-quality services of the scale required for comprehensive health care (whether underwritten publicly or privately) of the entire population. The difficulty is not only one of protecting realistic per capita ratios of doctors, hospital beds, dentists, etc. Also involved is the even more elusive calculation of the physical plant and (categories of) personnel requirements for the pronounced shift toward *preventive* health care, which a number of knowledgeable physicians consider as the next important frontier of modern medicine.

In broad outline form, what is already discernible on the horizon—and here we come back to our initial reference concerning the possible

impact of newly developed technology—is: 1) the extensive use of computers for large-scale recurrent screening and selected diagnostic purposes; 2) the progressive delegation to paramedical aides and other supportive personnel of the routine, recording, and other "housekeeping" functions in both the preventive and curative phases of medical care, and 3) the institution by government of the strongest possible financial and other incentives for training the professional, subprofessional, and technical specialists, including perhaps even the establishment and support by government of the necessary facilities to do so.

If this projection of circumstances within which the next *big* decision, that concerning the health care of the nation, will have to be taken is not too far off the mark, the public health aspect within the sum total of our health care concerns would appear to take on an altogether new dimension. Without detracting from the pilot role of Medicare and Medical Assistance legislation as referred to throughout this paper as pace setters of standards and goals toward comprehensive health care, the crucial importance of certain other legislation, such as that concerned with the planful exploration of heart disease, cancer, and stroke, and that pertaining to child health—both emphasizing inter alia screening, diagnostic, and preventive services—move into focus as potentially of equal importance. Again, only dimly yet discernibly, there begins to emerge—with the growing emphasis on environmental factors and on other noxious conditions begetting illness, and the aim of prevention and early detection of illness—a whole new public service or "social utility" function (more in the nature of freeways than of toll roads) as separate from, but serving as a foundation for, the sum total of prepayment and other provisions for treatment and cure.

A Possible Future Pattern of Comprehensive Health Care

Viewed from this particular angle, certain developments observable abroad take on new meaning and significance, chief among them, perhaps, the events that have taken place in Great Britain since the establishment of the National Health Service (NHS). I am referring to the impressive growth, in Britain, of a resurgent private voluntary insurance movement over and above the layer of complete free public services. It seems to me that this development has gone largely undetected and unevaluated.

The fact that in Britain today about 1.5 million people, all eligible

for and paying for the NHS, take out privately sponsored mutual insurance for hospitalization and surgical care—coupled with the further fact that a mere handful take advantage of similar opportunities in respect of doctors' services—can be interpreted, it seems to me, as striking evidence of a widespread inclination among the population to pursue different ends by different methods.

Time and space preclude a discussion of the possible motivations and other causes for this phenomenon. What seems evident is a widespread multiple concern among consumers. Without implying, from the British developments, an analogy in terms of specific solutions, some similarly pluralistic or composite approach in the United States to the nation's health appears to me not unlikely to evolve in the long run, both in view of the nation's long-range needs and in view of the variety of public and private resources that we can bring to bear upon them.

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